**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name**
TEXAS BACK INSTITUTE

**Respondent Name**
LIBERTY INSURANCE CORP

**MFDR Tracking Number**
M4-14-0955-01

**Carrier's Austin Representative**
Box Number 1

**MFDR Date Received**
NOVEMBER 25, 2013

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The documentation we submitted was supported by the operative report. The operative report clearly shows this procedure was performed stating a 'complete discectomy was performed removing all of the disk material to the opposite side as far anterior and posterior as possible.' I have highlighted for your convenience. Please review this procedure and allow payment for this."

**Amount in Dispute:** $3,342.83

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "As per the AMA/CPT description of this code (63102), the operative report does not support a vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); lumbar, single segment. The operative report documents only a complete discectomy only to prepare the interspace for the placement of a size 50mm X 13mm implant for interbody fusion…Liberty Mutual believes that Texas Back Institute has been appropriately paid for services rendered."

**Response Submitted by:** Liberty Mutual Insurance Co.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| April 8, 2013 | CPT Code 63102 | $3,342.83 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - B12-Services not documented in patient's medical records.
   - X133-This charge was not reflected in the report as one of the procedures or services performed.

- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

**Issues**

1. Does the documentation support billing of code 63102?

**Findings**

1. According to the submitted explanation of benefits the insurance carrier denied reimbursement for CPT code 63102 based upon reason codes "B12" and "X133".

   28 Texas Administrative Code §134.203(b)(1) "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   CPT code 63102 is defined as "Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); lumbar, single segment."

   The requestor noted in the operative report that "A complete discectomy was performed removing all of the disk material to the opposite side as far anterior and posterior as possible." Based upon the code descriptor, the operative report does not support billing CPT code 63102; therefore, the respondent's denial based upon reason codes B12" and "X133" is supported. As a result, reimbursement is not recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | 10/20/2014<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.